SHREWSBURY PUBLIC SCHOOLS MEDICATION ORDER

Name of Student_____ **Date of Birth**_____

Address_____ **Grade**_____
(street) (city/town)
Name of Licensed Prescriber_____ **Title**_____
Business Telephone Number_____

Medication_____
Route of administration_____ **Dosage**_____

Frequency_____ **Time(s) of Administration**_____

Date of Order_____ **Discontinuation Date**_____

Diagnosis_____

Any other medical condition(s) or drug allergies _____

Additional Information

1. **Special side effects, contraindications, or possible adverse reactions to be observed:**

_____

2. **Other medication being taken by the student:** _____

3. **The date of the next scheduled visit or when advised to return to prescriber**:_____

***Signature of Licensed Prescriber**: _____

1. **I give permission for the school nurse to administer medication as per this medication order.**
   _____ Yes **_____** No

2. **I give permission for the school nurse to instruct a trained, responsible adult in administering the above mentioned medication to my child on field trips.** **_____** Yes **_____** No

3. **I consent that my student may carry emergency medication at the secondary level**. Yes___ No____

*****_____
Parent Signature

*****_____
Home Telephone

_____
Work Telephone